

11812

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Saint Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patuxent River</u>				c. LENGTH OF STAY IN 1b <u>01 hr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lexington Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Station Hospital, USNAS</u>				d. STREET ADDRESS <u>39 Anderson Courts</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Joseph</u> Last <u>AMSTERDAM</u>				4. DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4 October 1960</u>	
9. AGE (In years last birthday) yrs. <u>01</u>		IF UNDER 1 YEAR Months <u>01</u> Days <u>01</u>		IF UNDER 24 HRS. Hours <u>01</u> Min. <u>01</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NA</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NA</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David (n) AMSTERDAM</u>				14. MOTHER'S MAIDEN NAME <u>Susan Louise EMBARRATO</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NA</u>		INFORMANT <u>FATHER: 39 Anderson Courts</u> <u>Lexington Park, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>776X</u> IMMEDIATE CAUSE (a) <u>PREMATURE BIRTH, Neonatal DEATH with</u> DUE TO <u>Immaturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>01 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>8:45-10-4</u> , 19 <u>60</u> , to <u>9:45-10-4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>9:45-10-4</u> , 19 <u>60</u> , and that death occurred at <u>9:45A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>D. S. Anderson</u> M.D. _____				PHYSICIAN'S NAME (Type) <u>D. G. ANDERSON LT MC USN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10/5/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Face Cemetery</u>	
22d. LOCATION (City, town, or county) _____ (State) _____				22e. LOCATION (City, town, or county) _____ (State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson - Leonardtown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
ISM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11786

1. PLACE OF DEATH o. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Chaptico		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Chaptico	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Richard Last Baker		4. DATE OF DEATH Month October Day 16 Year 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1905
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William M. Baker		14. MOTHER'S MAIDEN NAME Mary E. Bowman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Catherine Louise Baker Chaptico, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Lemon Cope 443X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Hypertensive C.V. disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH immed	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1955 to Oct 16, 1960 , that (I) (we) last saw the deceased alive on 10/16/60 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE J. H. [Signature]		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J. H. [Signature]		22d. ADDRESS Mechanicsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/19/60	
23c. NAME OF CEMETERY OR CREMATORY St. Joseph's		23d. LOCATION (City, town, or county) (State) Morganza, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		25a. REC'D BY REGISTRAR OCT 21 '60	
ADDRESS Leonardtwn, Maryland		25b. REGISTRAR'S SIGNATURE Arthur L. [Signature]	

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CERTIFICATE OF DEATH
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Susan Middle Lillian Last Banagan		4. DATE OF DEATH Month October Day 29 Year 1960	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1881
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Herbert		14. MOTHER'S MAIDEN NAME Rebecca Herbert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs Fred Mattingly		Address Avenue, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause last. (b) Uremia DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 17, 1945 to October 29, 1960 , that (I) was lost saw the deceased alive on October 28, 1960 , and that death occurred at 3 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert T. Fuchs		22b. DATE SIGNED 11/1/60	
22c. PHYSICIAN'S NAME (Type) Robert Fuchs M. D.		22d. ADDRESS Leonardtown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/31/60	
23c. NAME OF CEMETERY OR CREMATORY Sacred Heart		23d. LOCATION (City, town, or county) (State) Bushwood, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		25a. REC'D BY REGISTRAR DATE NOV 2 '60	
ADDRESS Leonardtown, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Fuchs	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11814

CERTIFICATE OF DEATH

11788

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Mechanicsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Mechanicsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		d. STREET ADDRESS Rural	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CECELIA Middle MARIA Last BUTLER		4. DATE OF DEATH Month October Day 11 , Year 19 60	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1898
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John F. Stevens		14. MOTHER'S MAIDEN NAME Priscilla Stewart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219 16 0738	
17. INFORMANT Gladys Butler		Address 839 Longfellow St. N.W. Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension Malignant 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/10 , 19 58 , to Oct 11 , 19 60 , that I last saw the deceased alive on Oct 11 , 19 60 , and that death occurred at 8 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Leonardtwn, Md. 10.12.60			
ACTUAL SIGNATURE Charles Greenwell		M.D. Leonardtwn, Md.	
PHYSICIAN'S NAME (Type) Charles Greenwell, MD		Leonardtwn, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/14/60	
22c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		22d. LOCATION (City, town, or county) (State) Hollywood, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE OCT 18 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraw			

1. PLACE OF DEATH a. COUNTY Saint Mary's		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake Bay, 700 yds		c. LENGTH OF STAY IN 1b 1 year	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) from East Corner of WST Breakwater, USNAS, Patuxent River, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Henry Hewitt		4. DATE OF DEATH October 18 1960	
5. SEX Male		6. COLOR OR RACE Cauc	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4 April 1924	
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days 	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aviator		12. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
13. BIRTHPLACE (State or foreign country) Ohio		14. CITIZEN OF WHAT COUNTRY? USA	
15. FATHER'S NAME (Deceased) Martin Steedman DODD		16. MOTHER'S MAIDEN NAME (Deceased) Isabel HEWITT	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 12-2-42-10-18-60		18. SOCIAL SECURITY NO. 271 20 1291	
19. INFORMANT Official U.S. Navy Records		20. ADDRESS USNAS, Patuxent River, Maryland	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries, Multiple, Extreme 860X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		22. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
23. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Aircraft Accident		24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) 	
25. TIME OF INJURY Month, Day, Year 5:00 p.m. 10-18 1960		26. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chesapeake Bay		28. (City or town) Chesapeake Bay (State) Md.	
29. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		30. CHIEF MEDICAL EXAMINER <input type="checkbox"/> J. H. MILLER LT MC USN, USNAS, Patuxent River, Maryland 10-19-60 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Leonardtown, Maryland	
31. EXAMINER'S NAME (Type) WM D. BOYD, M.D.		32. ADDRESS (Street, city, town, or county) 	
33. BURIAL, CREMATION, REMOVAL (Specify) Buried		34. DATE THEREOF 10/21/60	
35. NAME OF CEMETERY OR CREMATORY Toledo, Ohio		36. LOCATION (City, town, or country) (State) 	
37. FUNERAL DIRECTOR P.B. Robinson - Leonardtown, Md.		38. REC'D BY REGISTRAR OCT 24 '60	
39. REGISTRAR'S SIGNATURE Arthur L. Kneass		40. ADDRESS (Street, city, town, or county) 	



1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Birth: _____

5. Place of Birth: _____

6. Usual Residence: _____

7. Date of Death: _____

8. Time of Death: _____

9. Cause of Death: _____

10. Place of Death: _____

11. Signature of Medical Examiner: _____

12. Signature of Coroner: _____

13. Signature of Police Officer: _____

14. Signature of Witness: _____

15. Signature of Physician: _____

16. Signature of Nurse: _____

17. Signature of Undertaker: _____

18. Signature of Funeral Home: _____

19. Signature of Cemetery: _____

20. Signature of Burial Place: _____

21. Signature of Interment: _____

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY St. Marys MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) California	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital		d. STREET ADDRESS Rural	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle ROBERT Last ENNELS		4. DATE OF DEATH Month October Day 18 Year 1960	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1917
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James R. Ennels		14. MOTHER'S MAIDEN NAME Alice M. Gladden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO.	
17. INFORMANT Alice M. Ennels - California, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 16 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-18-60 , 19 10-18 , to 10-19 , that I last saw the deceased alive on 10-18-60 , 19 10-18 , and that death occurred at 6 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. H. Patrick		ADDRESS (Street, city or town, state) Lexington Park, Md.	
PHYSICIAN'S NAME (Type) Wm. H. Patrick, MD		DATE SIGNED 10/19/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/21/60	
22c. NAME OF CEMETERY OR CREMATORY Holy Face Cemetery		22d. LOCATION (City, town, or county) (State) Great Mills, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P. B. Robinson		ADDRESS Lexington Park, Md.	
24a. REC'D BY REGISTRAR OCT 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11816

CERTIFICATE OF DEATH

11791

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		d. STREET ADDRESS Rural	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Eva Middle McGinley Last Graves		4. DATE OF DEATH Month October Day 29 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1883
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John McGinely		14. MOTHER'S MAIDEN NAME Annie Dixon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mazie M. Clemson		Address 156 Conduct Street, Annapolis, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive heart failure DUE TO (b) Arteriosclerotic CV disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid arthritis			INTERVAL BETWEEN ONSET AND DEATH 1 week 10 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1928 to Oct 29, 1960 , that I last saw the deceased alive on Oct 28, 1960 , and that death occurred at 5:50 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Roy Guythar		DATE SIGNED 10/30/60	
PHYSICIAN'S NAME (Type) J. Roy Guythar, MD		ADDRESS (Street, city or town, state) Mechanicsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/1/60	22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	22d. LOCATION (City, town, or county) (State) Laurel Grove, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson		ADDRESS Leonardtown, Md.	
24a. REC'D BY REGISTRAR NOV 2 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

1918

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 45	
4. PLACE OF BIRTH Maryland		5. DATE OF BIRTH Jan 15 1873		6. PLACE OF DEATH Baltimore	
7. OCCUPATION Carpenter		8. CAUSE OF DEATH Heart Disease		9. MEDICAL HISTORY None	
10. DATE OF DEATH Jan 25 1918		11. TIME OF DEATH 10:30 AM		12. SIGNATURE OF PHYSICIAN J. H. Harris	
13. SIGNATURE OF WITNESSES J. H. Harris		14. SIGNATURE OF DECEASED J. H. Harris		15. SIGNATURE OF FUNERAL HOME J. H. Harris	
16. SIGNATURE OF REGISTRAR J. H. Harris		17. SIGNATURE OF CLERK J. H. Harris		18. SIGNATURE OF CHURCH J. H. Harris	
19. SIGNATURE OF MINISTER J. H. Harris		20. SIGNATURE OF BURIAL J. H. Harris		21. SIGNATURE OF INTERMENT J. H. Harris	
22. SIGNATURE OF CREMATION J. H. Harris		23. SIGNATURE OF REINTERMENT J. H. Harris		24. SIGNATURE OF REINTERMENT J. H. Harris	
25. SIGNATURE OF REINTERMENT J. H. Harris		26. SIGNATURE OF REINTERMENT J. H. Harris		27. SIGNATURE OF REINTERMENT J. H. Harris	
28. SIGNATURE OF REINTERMENT J. H. Harris		29. SIGNATURE OF REINTERMENT J. H. Harris		30. SIGNATURE OF REINTERMENT J. H. Harris	
31. SIGNATURE OF REINTERMENT J. H. Harris		32. SIGNATURE OF REINTERMENT J. H. Harris		33. SIGNATURE OF REINTERMENT J. H. Harris	
34. SIGNATURE OF REINTERMENT J. H. Harris		35. SIGNATURE OF REINTERMENT J. H. Harris		36. SIGNATURE OF REINTERMENT J. H. Harris	
37. SIGNATURE OF REINTERMENT J. H. Harris		38. SIGNATURE OF REINTERMENT J. H. Harris		39. SIGNATURE OF REINTERMENT J. H. Harris	
40. SIGNATURE OF REINTERMENT J. H. Harris		41. SIGNATURE OF REINTERMENT J. H. Harris		42. SIGNATURE OF REINTERMENT J. H. Harris	
43. SIGNATURE OF REINTERMENT J. H. Harris		44. SIGNATURE OF REINTERMENT J. H. Harris		45. SIGNATURE OF REINTERMENT J. H. Harris	
46. SIGNATURE OF REINTERMENT J. H. Harris		47. SIGNATURE OF REINTERMENT J. H. Harris		48. SIGNATURE OF REINTERMENT J. H. Harris	
49. SIGNATURE OF REINTERMENT J. H. Harris		50. SIGNATURE OF REINTERMENT J. H. Harris		51. SIGNATURE OF REINTERMENT J. H. Harris	
52. SIGNATURE OF REINTERMENT J. H. Harris		53. SIGNATURE OF REINTERMENT J. H. Harris		54. SIGNATURE OF REINTERMENT J. H. Harris	
55. SIGNATURE OF REINTERMENT J. H. Harris		56. SIGNATURE OF REINTERMENT J. H. Harris		57. SIGNATURE OF REINTERMENT J. H. Harris	
58. SIGNATURE OF REINTERMENT J. H. Harris		59. SIGNATURE OF REINTERMENT J. H. Harris		60. SIGNATURE OF REINTERMENT J. H. Harris	
61. SIGNATURE OF REINTERMENT J. H. Harris		62. SIGNATURE OF REINTERMENT J. H. Harris		63. SIGNATURE OF REINTERMENT J. H. Harris	
64. SIGNATURE OF REINTERMENT J. H. Harris		65. SIGNATURE OF REINTERMENT J. H. Harris		66. SIGNATURE OF REINTERMENT J. H. Harris	
67. SIGNATURE OF REINTERMENT J. H. Harris		68. SIGNATURE OF REINTERMENT J. H. Harris		69. SIGNATURE OF REINTERMENT J. H. Harris	
70. SIGNATURE OF REINTERMENT J. H. Harris		71. SIGNATURE OF REINTERMENT J. H. Harris		72. SIGNATURE OF REINTERMENT J. H. Harris	
73. SIGNATURE OF REINTERMENT J. H. Harris		74. SIGNATURE OF REINTERMENT J. H. Harris		75. SIGNATURE OF REINTERMENT J. H. Harris	
76. SIGNATURE OF REINTERMENT J. H. Harris		77. SIGNATURE OF REINTERMENT J. H. Harris		78. SIGNATURE OF REINTERMENT J. H. Harris	
79. SIGNATURE OF REINTERMENT J. H. Harris		80. SIGNATURE OF REINTERMENT J. H. Harris		81. SIGNATURE OF REINTERMENT J. H. Harris	
82. SIGNATURE OF REINTERMENT J. H. Harris		83. SIGNATURE OF REINTERMENT J. H. Harris		84. SIGNATURE OF REINTERMENT J. H. Harris	
85. SIGNATURE OF REINTERMENT J. H. Harris		86. SIGNATURE OF REINTERMENT J. H. Harris		87. SIGNATURE OF REINTERMENT J. H. Harris	
88. SIGNATURE OF REINTERMENT J. H. Harris		89. SIGNATURE OF REINTERMENT J. H. Harris		90. SIGNATURE OF REINTERMENT J. H. Harris	
91. SIGNATURE OF REINTERMENT J. H. Harris		92. SIGNATURE OF REINTERMENT J. H. Harris		93. SIGNATURE OF REINTERMENT J. H. Harris	
94. SIGNATURE OF REINTERMENT J. H. Harris		95. SIGNATURE OF REINTERMENT J. H. Harris		96. SIGNATURE OF REINTERMENT J. H. Harris	
97. SIGNATURE OF REINTERMENT J. H. Harris		98. SIGNATURE OF REINTERMENT J. H. Harris		99. SIGNATURE OF REINTERMENT J. H. Harris	
100. SIGNATURE OF REINTERMENT J. H. Harris		101. SIGNATURE OF REINTERMENT J. H. Harris		102. SIGNATURE OF REINTERMENT J. H. Harris	

11809

CERTIFICATE OF DEATH

11792

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital		d. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print) First ODIE Middle GERTRUDE Last GREEN		4. DATE OF DEATH Month October Day 17 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 8, 1881
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter McKay		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Bernard F. Green - Ridge, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Atherosclerosis DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 8 hours 5 years 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral hemorrhage 1959		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1, 1960 , to Oct 17, 1960 , that I last saw the deceased alive on Oct 13, 1960 , and that death occurred at 1 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE P.J. Bean M.D.		ADDRESS (Street, city or town, state) Great Mills, Maryland DATE SIGNED 10/18/60	
PHYSICIAN'S NAME (Type) P.J. Bean, MD		Great Mills, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/20/60	22c. NAME OF CEMETERY OR CREMATORY St. Michaels	22d. LOCATION (City, town, or county) (State) Ridge, Md.
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson		ADDRESS Leonardtown, Md.	
24a. REC'D BY REGISTRAR DATE OCT 24 '60		24b. REGISTRAR'S SIGNATURE William S. Robinson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle Catherine Last Marshall		4. DATE OF DEATH Month October Day 26 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 8, 1898
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Guy		14. MOTHER'S MAIDEN NAME Molly Evans	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 078	
17. INFORMANT Arthur Lawes Marshall, Abell, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of Heart DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) Myocardial Infarction DUE TO (c) ASCVD		INTERVAL BETWEEN ONSET AND DEATH Minutes days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 10:40 a.m. 10/26/60		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 10-22, 1960 10-26, 1960	
21. I certify that (I) (this hospital) attended the deceased from 10/22, 1960 to 10-26, 1960 , that (I) (we) last saw the deceased alive on 10/26, 1960 and that death occurred at 10:40 M, from the causes and on the date stated above.			
22a. SIGNATURE James P. Jarboe		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JAN		22d. ADDRESS GREAT MILLS, Mechanicsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/29/60	
23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		23d. LOCATION (City, town, or county) (State) Leonardtwn, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		25a. REC'D BY REGISTRAR NOV 2 '60	
ADDRESS Leonardtwn, Maryland		25b. REGISTRAR'S SIGNATURE Arthur L. Haas	

1. *Introduction*

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10/25/01 08 01

11301

CERTIFICATE OF DEATH

11315

Blank form with horizontal lines for text entry.

CHIEF OF POLICE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

11818

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11795

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY St. Mary's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY St. Mary's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural Clements | | c. LENGTH OF STAY IN 1b
Life | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
John Walter Cochran Raley | | 4. DATE OF DEATH
Month October Day 23 Year 1960 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 9, 1908 |
| 9. AGE (In years last birthday)
52 yrs. | | 10. IF UNDER 1 YEAR
Months 52 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY
Farm | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John A. Raley | | 14. MOTHER'S MAIDEN NAME
Mary Elizabeth Farr | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
Nellie L. Raley Clements, Maryland | |
| 17. INFORMANT
Nellie L. Raley Clements, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CRUSHING INJURIES TO CHEST
DUE TO IMMED
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) 835X
DUE TO Working to close to ditch & tractor turned over on himself
(c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Interval between onset and death | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
disking land | |
| 20c. TIME OF INJURY
Month, Day, Year
9:30 a.m. 10/23, 1960 | | 20d. INJURY OCCURRED
While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Farm | | 20f. (City or town) (County) (State)
Clements, St. Mary's, Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE
William D. Boyd M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
William D. Boyd M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED
10/23/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10/25/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Six Sacred Heart | | 22d. LOCATION (City, town, or county) (State)
Bushwood, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W. Clarke Mattingley | | ADDRESS
Leonardtwn, Maryland | |
| 24a. REC'D BY REGISTRAR
Oct 26 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Frank | |

01 250MTR-11-12N TO THINSTRASS STATE CHATMAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
15M 9-59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11811
11796
Item 2 Film 62-4 11-21-60 et

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY St. Mary's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Leonardtown | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 7 Park Hall | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
St. Mary's Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Baby Middle Girl Last Schisler | | 4. DATE OF DEATH
Month Oct Day 11 Year 19 60 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 11, 1960 |
| 9. AGE (In years last birthday)
8 | | 10. IF UNDER 1 YEAR
Months — Days — Hours — Min. — | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Charles Schisler | | 14. MOTHER'S MAIDEN NAME
Teresa Hood | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mother | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Insufficiency
773-5 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (1) (this hospital) attended the deceased from 10-10, 1960 to 10-11, 1960 , that (1) (we) last saw the deceased alive on 10-11, 1960 , and that death occurred at 7:00 A.M., from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
James P. Jarboe | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
James P. Jarboe M.D. | | 22d. ADDRESS
Great Mills, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/11/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY
St. Aloysius | | 23d. LOCATION (City, town, or county) (State)
Leonardtown, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
W. Clarke Mattingley Leonardtown, Maryland | | 25a. REC'D BY REGISTRAR
OCT 14 '60 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Kline | | | |

2078193XVI

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|---|--|---|--|---|--|---|---|--|
| 1. PLACE OF DEATH
o. COUNTY St. Mary's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY St. Mary's | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural Avenue | | | c. LENGTH OF STAY IN 1b
Life | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural Avenue | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First Thomas Middle Matthew Last Wise | | | | 4. DATE OF DEATH
Month October Day 27 Year 1960 | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Jan. 20, 1880 | | |
| 9. AGE (In years last birthday)
80 yrs. | | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | | IF UNDER 24 HRS.
Hours <input type="checkbox"/> Min. <input type="checkbox"/> | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
State of Maryland | | | 10b. KIND OF BUSINESS OR INDUSTRY
Conservation | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Dominic Wise | | | | 14. MOTHER'S MAIDEN NAME
Selina Yates | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT
Frances A. Wise Address Avenue, Maryland | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
450.0 DUE TO heart failure
senile arteriosclerosis
melanoma GB.
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M., from the causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE
Michael Barbarich M. D. | | | | 22b. DATE SIGNED
NOV 2 '60 | | 22c. PHYSICIAN'S NAME (Type)
Michael Barbarich M. D. | | |
| 22d. ADDRESS
Lexington Park, Maryland | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/29/60 | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart | | 23d. LOCATION (City, town, or county) (State)
Bushwood, Maryland | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
W. Clarke Mattingley | | | | 25a. REC'D BY REGISTRAR
NOV 2 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Frank | | |

11-11-11

CERTIFICATE OF DEATH

11-11-11

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.